

## LABORATORY PERTUSSIS TEST REQUEST FORM NORTH DAKOTA DEPARTMENT OF HEALTH DIVISION OF MICROBIOLOGY SFN 54154 (Rev. 08-2004)

Telephone: 701.328.6272 Fax: 701.328.6145

* FOR LABORATORY USE *	

Patient's Name (Last)				(First	t)						(MI)
Patient's Address			Date of Birt	h	Sex			Race	e / Ethni	icity	
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City			State	Zip Code	Zip Code Medi		Medicaid / Medicare Number				
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FACILITY					Cus	tomer cou	ic				
Address			State	State Zip Code Telephone Number							
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Please check appropriate from <b>both</b> High Risk an					ympton	natolog	gy. Pa	tient n	nust n	neet c	riteria
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Priority Criteria					Symptomatology						
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Health-care worker				wn contact to tussis Case		Kn			ase		ussis
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Health-care worker			Per Cough of $\geq$ 7	wn contact to tussis Case days		Kno	gh of a	Ca	ase iratioi		ussis
Health-care worker			Per Cough of ≥7	wn contact to tussis Case days		Kno	gh of a	Ca any du	ase iratioi		ussis
Health-care worker Child/staff in day care f	Facility*		Per Cough of $\geq$ 7 Cough with Whoop	wn contact to tussis Case days paroxysms		Kno	gh of a	Ca any du	ase iratioi		ussis
Health-care worker  Child/staff in day care f  Day care criteria also may be a where young children are assem	Facility*		Per Cough of ≥7 Cough with Whoop Post-tussive	wn contact to tussis Case days paroxysms		Kno	gh of a	Ca any du	ase iratioi		ussis
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